Community Health Centers: Part of the Safety Net

By Mary Beth Frideres, RN
Montana Primary Care Association

The "health care safety net" is a phrase you will hear more in the future. It is meant to describe services that are available to "catch" people in this country who are not able to use the traditional health care system and, therefore, "fall through the cracks." Most often, this is due to an individual's poor financial situation, but it can also be due to not having health insurance, or not having enough or the right kind of health insurance, or not speaking English, or not feeling accepted because of race or religion or culture or sexual orientation, or because people live in areas of the country where health care providers are scarce. The truth is that many Americans do not have ready access to medical care. Unfortunately, the number is growing

Safety net services are provided by a nationwide patchwork of individuals and organizations. The availability and scope of the services varies widely across the country. Included in the mix are federally qualified health centers (including Community Health Centers, Migrant Health clinics, and Healthcare for the Homeless clinics), certified rural health clinics, National Health Service Corp providers, hospitals and their emergency departments, Indian Health Service and urban Indian clinics, public health departments, community mental health centers, family planning clinics, and Critical Access Hospitals. In some communities, teaching and community hospitals, private physicians, and ambulatory care sites with demonstrated commitment to serving the poor and uninsured, fulfill the role of core safety net providers.

Typically, safety net providers exist in close proximity to vulnerable rural or urban populations, offering access to services without regard to health insurance, or ability to pay, or both. Most are able to do this because they receive some type of benefit for serving impoverished and disadvantaged populations from their county, state and/or the federal government.

Montana has its own assortment of safety net providers, and like other areas of the country, their ability to continue to provide services is being tested by financial pressures, changes in the health care marketplace, and increasing numbers of uninsured. But the news is not all bad - one source of health care safety net services, Community Health Centers (CHCs) is growing and has the potential to grow even more to meet the needs of Montana's underserved and vulnerable residents.

There are 1,029 CHCs in operation across the country today. Collectively, these centers

serve more than 11 million patients (4.4 million of whom are uninsured) through 3,200 delivery sites in urban and rural communities in all fifty states, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands.

Community Health Centers are private, not-for-profit, consumer-directed health care corporations that receive a federal grant under the U.S. Public Health Service Act to provide comprehensive primary and preventive health care. This care is not free - clinic fees are based on the patient's ability to pay (sliding scale). Primary care can be best defined as the type and scope of medical care that you receive from your family doctor.

Health centers typically have a multidisciplinary staff - physicians, nurse practitioners, physician assistants, nurses, therapists, dentists, and support workers. Services include primary care visits, health education, disease screening, case management, laboratory services, dental care, pharmacy services, mental health and substance abuse counseling, and social services. Some offer evening and weekend hours for working families, provide care at multiple sites, use mobile clinics to serve hard-to-reach populations, and may employ multi-lingual staffs. All CHCs have a 24-hour system for after-hours calls and emergencies.

In Montana, CHCs, Migrant Health clinics, and Health Care for the Homeless clinics are funded under the U.S. Public Health Service Act. (See map.) These clinics are also commonly referred to as Federally Qualified Health Centers (FQHCs) because they meet rigorous federal standards related to quality of care, as well as cost, and they are qualified to receive reimbursement under Medicaid and Medicare law that is based on their cost of providing care.

There are 9 Community Health Centers in Montana:

Ashland Community Health Center, Ashland
Deering Community Health Center, Billings
Community Health Partners, Livingston (with a satellite clinic in Bozeman)
Community Health Center, Butte (with satellite clinics in Twin Bridges and Dillon)
Cooperative Health Center, Helena (with a satellite clinic in Lincoln)
Cascade Community Health Care Center, Great Falls
Sweet Medical Center, Chinook
Lincoln County Community Health Center, Libby
Partnership Health Center, Missoula

*** ***See author's note on new developments at the end of this article***

One Migrant Health Program:

Montana Migrant Council, Billings (with 10 clinic sites across the state)

And one Healthcare for the Homeless Program:

Deering Community Health Center, Billings
(with satellites in Helena, Butte, and Missoula).

Community Health Center dollars flow from the federal government directly to Montana

community boards that have policy-making authority and responsibility for the center's management. At least 51 percent of a health center board must be comprised of patients who utilize the health center's services. Such boards also include local business, civic, and community leaders and others who bring expertise and experience. Each board ensures that health center services are tailored to the unique needs of that community.

Currently, Montana CHCs receive more than $8,500,000 federal grant dollars. These dollars are supplemented by health center revenue from Medicaid, Medicare, state and local government grants/contracts, private insurance payments, patient fees, foundation grants and private donations. In calendar year 2002, Montana CHCs spent more than $17,000,000 providing primary care services. These dollars are important support to local communities. They employed more than 257 (FTE) Montanans, and they provided over 176,700 medical, mental health/substance abuse, and/or dental services to 48,500 Montana residents (30,476 of whom were uninsured).

Most of the CHCs in Montana are independent entities, organized as 501(c)(3) not-for-profit corporations. Understanding that there will never be enough federal dollars to address all local health care needs, the federal Bureau of Primary Health Care developed the Community Health Center model around collaboration and partnership. CHCs have close relationships with all public and non-profit health-related service providers in their area, as well as many private providers, and have developed cost-effective and resource-sharing approaches to address the needs of their patients. For example, hospitals and specialists in many areas provide discounted services to CHC patients. These partnerships, which focus on keeping CHC patients healthy and without need of hospitalization, reduce the incidence of uncompensated, complex care.

There are three Montana CHCs that reside within county public health departments and, therefore, county administrative structures. They were created through an arrangement between the center's non-profit board, the county board of health, and the board of county commissioners. They are the Cooperative Health Center in Helena (Lewis and Clark City/County Health Department), the Cascade Community Health Care Center (Cascade City/County Health Department), and Partnership Health Center (Missoula City/County Health Department). The two programs have complementary roles. County health departments traditionally focus on preventive health services while providing some direct primary care, and CHCs provide some preventive health services as part of their primary mission to offer direct medical, dental, and mental health care – the type you would find in a private physician, dentist, and/or mental health office.

One of the essential services of public health is to "link people to needed personal health care services and assure provision of health care when otherwise unavailable" [U.S. Public Health Service, 1994]. The founders of these organizations considered the advantages of co-location of public health and health center services. They believed that program cost could be reduced, efficiency could be maximized, and patient access could be facilitated with such an arrangement. The county, the CHC board, and the county board of health applied for these CHC grants as "co-applicants."

In these arrangements, and as required by law, the health center board is the governing entity of the health center, retaining all programmatic and policy-making authority and responsibility for the center's management and budget, including the hiring of the center's Executive Director. The health center board, however, agrees to comply with administrative and fiscal procedures used by the county. Health center employees are hired as county employees, operate under the personnel policies of the county, and receive county benefits such as health insurance and retirement. The board of health, which governs the operation of the county health department, agrees to assure that health center and health department funds are kept separate and that health department programs are run independently of the health center. Typically, a representative from the board of health and the county commission become members of the governing board of the health center. This can facilitate collaboration on program development and delivery. For example, the board of health, through its community health assessment process, may determine that access to dental care is the number one public health priority for its citizens. The board of health representative on the health center board can voice this concern and work with health center administrators to make sure that the health center is doing everything it can to meet the need for affordable, quality dental care. Another advantage of this arrangement is the convenience afforded to the health center and health department patients. Having primary care and public health preventive services in one location facilitates easy access for patients who are in need of both.

Because of the divided authorities in this co-applicant model, however, these programs face challenges not seen in independent CHCs. Most of the critical issues occur at the interface between creating a successful family practice clinic and participating in a county governmental structure. For example, the recruitment of quality primary care physicians is competitive. Public and private practices across the country are offering more and more "perks" to provider candidates in order to recruit them to practice in their organizations. These additional benefits may not fit in a typical Montana county employee benefit package and structures may need to be altered to allow competitive recruitment efforts. The Health District, created to house the Yellowstone City-County Health Department, the Deering CHC, and various other public health service programs, was created to permit more flexibility to meet these types of challenges.

The number of Montana CHCs and their satellites has grown in the past few years. This is primarily due to the initiative to increase the number of CHCs put forth by President Bush:

> "I strongly support these Community Health Centers because they are compassionate, they are cost-effective, and America needs more of them. And so I've set this goal: We need 1,200 more Community Health Centers over the next five years to make sure government fulfills its commitment to the need."
>
> President George W. Bush, 2/11/02, Milwaukee, Wisconsin

In October of this year, we will begin year three of the President's five year initiative. In the first two years, seventeen Montana communities expressed interest in developing an application for a Community Health Center grant. Of those, six applied and three have been funded. We are awaiting a funding decision on the remaining three applications. In addition, two new satellites of an established CHC have opened in rural sites.

This is an important opportunity for Montana communities that can demonstrate a high level of need, to present a sound proposal to meet the need, rapidly initiate their proposal, and demonstrate responsiveness to their local health care environment by having established collaborative and coordinated delivery systems for the provision of primary health care to their underserved. Applications are welcome from American Indian and Tribal organizations, as well, and applications from rural and frontier areas will be given priority.

The staff of the Montana Primary Care Association (406-442-2750) can provide excellent technical assistance to any community or organization wishing to apply for a CHC grant.

*** *Author's Note: on August 26, 2003, after this article was submitted, the communities of Miles City and Cut Bank were notified by HRSA that they have been awarded community health center grants. Congratulations from MPCA!*

The truth is that many Americans do not have ready access to medical care. Unfortunately, that number is growing.

One source of health care safety net services is growing and has the potential to grow even more to meet the needs of Montana's underserved and vulnerable residents - Community Health Centers (CHCs).

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Introduction

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Montana's Local Boards of Health: Three Examples

While Montana's statutes prescribe the duties and authority of all local health departments, the implementation of those statutes takes on markedly different characteristics across the state. As one local health officer stated, "When you've seen one local health department in Montana, you've seen one local health department."

The vastly different needs, constraints, resources and demands for service between and among each of Montana's counties require that local boards of health create locally appropriate ways to provide the core functions of the public health system - assessment, policy development and assurance.

Following are descriptions of three distinctly different types of local boards of health. They represent the most populous county, a mid-sized county, and a smaller county. These examples are meant to highlight the diversity in Montana's local public health delivery system. Each provides examples of innovative approaches to protecting and promoting health that were developed to meet unique local needs. These examples may be of interest to other jurisdictions.

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one local
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local health
department

The Yellowstone City-County Board of Health is the
governing,
policy-setting and
operating board for the health department. They are a progressive, risk-taking board that establishes the

long-term vision of a public health and health services district for Yellowstone County.

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Yellowstone City-County Health Department is a multi-jurisdictional health service district which was created in 1998. It is a governmental entity created by ordinances of Yellowstone County, the City of Billings and the City of Laurel establishing an interlocal agreement between the three entities. That agreement allowed the creation of a public health department under Title 50 and the creation of a health services department under Title 7, Montana Code Annotated. The board of health is comprised of 12 members each serving a three year term. Two members are appointed by the Yellowstone County Commissioners, two members are appointed by the Billings Mayor with approval of the Billings City Council; one member is appointed by the Laurel Mayor with approval of the Laurel City Council; the remaining seven members are board of health appointments. Vacant board-appointed positions are advertised, applicants are interviewed by a board committee with recommendations made to the full board for a vote. Governmental positions are filled according to regulation or protocol of the appointing unit. The board of health elects a Chairman, Vice-Chairman and Secretary-Treasurer for one year terms. There is no limit on number of terms for board positions or elected office.

Although it is not required that a county commissioner serve on the board of health in an official capacity, one representative from the commission has filled a county appointed slot since creation of the health district. Quite often two commissioners are in attendance and on occasion all three Yellowstone County Commissioners attend the monthly board of health meetings. Informal communication is constant between the commission and the health officer as public health business is conducted; formal sessions are scheduled with commissioners and appropriate board of health members if necessary. The board of health employs the Chief Executive Officer/Health Officer who reports directly to them.

The health officer continues to fill the role of lead local public health official at the present time. We are in the process of hiring a Director of Public Health with the intent of transferring responsibility and accountability to that person. As Montana law requires the health officer to relate and report to the board of health, the overall information and communication will continue to flow between the health officer, the board of health and the county commissioners as necessary. It is unclear how much of the role can actually be delegated, and we will be learning as we develop a new role in this department and community.

The Yellowstone City-County Board of Health is the governing, policy-setting and operating board for the health department. They are a progressive, risk-taking board that establishes the long-term vision of a public health and health services district for Yellowstone County. They evaluate and make decisions for assistance and service outside of Yellowstone County upon request.

The board of health is definitely a policy-setting group. The board has a balance of private business, governmental, educational, medical and legal representation, their deliberations and strategic policy decisions establish a strong basis for current and future public health activities in this region.

The best example of a successful Board of Health project was the positive vote for a mill levy increase for public health services in Yellowstone County. Our department was funded at historically low levels for its entire existence. Due to I-105 and other legislative restrictions, the only way to increase resources for the health department was to request an increase in local taxes. The Board of Health held two strategic planning meetings before deciding to request the additional mills. It created a corporate structure to raise funds to support the effort; contracted for a survey research project to determine the possibility of success and completed community education sessions. The board conducted numerous education sessions, newspaper and TV interviews, a door-to-door talking campaign, and yard signage activities in order to pass the mill levy. There were approximately 48,000 votes cast in the November, 2002 election— we passed the levy by 28 votes!

The mill levy approved by Yellowstone County voters in November 2002 will provide an additional one million dollars to the annual budget beginning in November 2003. This amount may vary from year to year depending on the change in the value of a mill. These dollars will provide additional services in the areas of environmental health, disease control, family health, maternal child health, private duty program, school nurse program, visiting nurse services, health promotion and public health services. These services will include an increase in restaurant/pool/subdivision inspections, immunizations and sexually transmitted disease (STD) testing, case management for senior and family services, health promotions to link patients to needed health services, low income in-home personal care services and others.

The mill levy election represents a true success story!

Yellowstone City-County Board of Health
Billings, Montana

By Lil Anderson, RN, Director / Health Officer

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Lake County is located in the scenic Mission Valley area of western Montana, and encompasses 1,494 square miles. The total county population is 26,507. Much of the Flathead Reservation is located in Lake County, and the American Indian population numbers 6,306. (Population data is from 2002 Montana County Health Profiles). The town of Polson is the county seat.

The Lake County Board of Health membership consists of four members at large and two of the three current county commissioners, for a total of six voting members. Members at-large are appointed by the commissioners and serve for staggered three year terms set by the commissioners. Ex-officio members who regularly attend the quarterly meetings include the County Health Officer, and the department directors for environmental health and public health. In addition to the quarterly meetings, the board of health holds additional meetings for public hearings on variance requests for septic systems or other matters. The directors for environmental health and public health usually see that the board of health dates are set and the agenda is formulated collaboratively between the two departments.

When a vacancy needs to be filled, the at-large position is advertised in the weekly area newspaper, and interested individuals are asked to respond with a letter to the county commissioners, who then make the appointment to fill the vacancy if the candidate is suitable.

Our current health officer is a practicing physician, a Doctor of Osteopathy, and has a PhD. He serves in the health officer capacity via a contractual agreement. This agreement is renewed annually. Lake County provides liability coverage for performance of his duties as health officer, but the health officer maintains professional liability coverage for his independent work activities. The health officer has no regular working hours other than attendance at the board of health meetings, and serves as an advisor and signatory to the public health and environmental health departments. The environmental health and public health department directors consult with the health officer as needed. Most informal communication from the health officer to the board of health and/or the county commissioners comes through the directors of the environmental health and public health departments.

Programmatic decisions and policies within the departments are usually made through meetings with the county commissioners without the involvement of the board of health, which serves the public health and environmental health department heads in an advisory capacity. The board of health is not administratively involved with budget development, budget approval, or operations; this function lies with the county commissioners. The county commissioners oversee

and approve the annual budgets for the public health and environmental health departments, and the department heads formally report directly to the commissioners regarding budgetary and programmatic issues.

Currently, the board of health is involved with monitoring the development of a joint county-tribal Biting Animal Program which involves a Memorandum of Understanding (MOU), protocols and contract agreements between the county and the tribes as well as three incorporated towns within the county/reservation boundaries.

In the past, response to animal bites in Lake County and on the reservation has been done by a number of different responders depending on where the incident took place. The county has a vicious animal ordinance in place which recognizes only dogs. The three incorporated towns in Lake County and on the reservation—Polson, Ronan, and St. Ignatius—respond independently to animal bites within their city limits. The cities of Polson and Ronan each have a part-time designated animal control officer, but both officers agree that resources are limited. The tribe has an ordinance and a designated animal control officer who can officially respond only to animal bites occurring on the Tribal Housing Authority's grounds—a limited area in the vicinity of Pablo.

The board of health recognizes that response to animal bite incidents within the county and on the reservation is inconsistent due to complex jurisdictional issues, limited resources, and a county ordinance that is limited to dog bites. To address these problems, a series of meetings between county, city, and tribal officials has taken place over the summer months. A county commissioner, the Polson and Ronan animal control officer, the county public health and environmental health services directors, Tribal Housing Authority personnel, and the tribal animal control officer have attended these meetings. They have drafted an MOU which expresses a desire to work together to develop a common protocol for handling animal bites within our communities.

When finalized, this will certainly be a success story. It will provide consistent response to animal bite incidents in Lake County, whether the incident occurs inside city limits, on reservation land, or on fee, allotment, trust or lease lands. Rabies prevention is the driving public health concern, and the revised ordinance will address not only dogs, but also cats and ferrets. Resources will be increased because of the partnering commitment between the county, the tribe and the incorporated towns. Public health will be an integral part of the protocol loop, providing for better management of follow-up with the medical community. While much of the collaborative work has taken place at the ground level, the board of health has been involved in following the progress and will give final approval of the agreement and the revised ordinance.

Lake County Board of Health

By Linda Davis, RN, BSN
Director of Health Services

Programmatic

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involvement of the Board of Health, which serves the public health and environmental health department heads in an
advisory capacity.

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The board of health for Sweet Grass County is actually a City-County Board of Health. The board is comprised of all three county commissioners, the mayor of the City of Big Timber and one city council member, appointed to the board by the mayor.

The board holds regular monthly meetings over lunch at a local restaurant. Special meetings, when called, are held at the county commissioners' office. Special meetings may be called by a board member or a public health official (such as the county health officer, county health nurse, or county sanitarian).

The board is updated each month on public health in the county through the reports of the public health officials. The local health officials communicate as needed between board meetings. The sanitarian and health nurse are county employees and as such, answer to the county commissioners. The county health officer is a physician's assistant at the local medical clinic (a county facility) and is not paid for his services as health officer. Historically, the county health officer has been mostly involved in communicable disease investigation and signing the immunization orders for the health department. Public health authority rests primarily with the board of health, however, some authorities are held by the health officer according to state statute. Activities through which pubic health policy is carried out are delegated to the health officials and are dictated by Montana law.

The role of the local board of health has evolved, as there has been a greater focus on public health across Montana and the United States. A few years ago, the monthly meetings usually consisted of a sanitarian's report, a nurse's report and then perhaps consideration of a septic system waiver request. As public health emergency plans have been developed and local health officials have

become aware of increasing responsibilities, the board of health has become more of a policy setting body.

The work of the local board of health that stands out most to me right now is the development of the public health emergency plan. This plan is a product of efforts by the board of health, local health officials and the members of the Local Emergency Planning Committee (LEPC). The plan demonstrates an incredible ability to work together and overcome obstacles to protect the health and safety of our citizens. I think we can be really proud of what's been accomplished.

Our LEPC includes representatives from the sheriff's office, disaster and emergency services, county road department, U.S. Forest Service, a local veterinarian, Big Timber City Council, volunteer fire department, county commissioners, public health, EMS/ambulance, public information officer, and Department of Natural Resources and Conservation. Other agencies have participated as well, depending on the topic to be covered.

Essentially, the LEPC plans for the management of emergencies and reviews the event to

improve emergency plans and performance. The LEPC's experience base and context has been integral to the development of Sweet Grass County's public health emergency plan. The LEPC's knowledge of emergency management involving multiple agencies and the incident command system were particularly helpful during the development of the public health emergency plan. The LEPC provides an excellent opportunity to build relationships and develop skills beforehand that are crucial to effective emergency management. The public health emergency plan was funded by the Montana Department of Public Health and Human Services through a cooperative grant with the Centers for Disease Control and Prevention.

Sweet Grass City-County Board of Health

By Jeanne Conner, RN
County Health Nurse

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Richland County Board of Health Evaluation, Orientation and Training

By Judy LaPan, MS, MBA
Administrator

When you look beyond the daily programs provided in a typical Montana county, it becomes apparent that the health department plays a large role in assuring a minimum standard of health; by providing the core functions of assessment, assurance and policy development. Program implementation is only a fraction of the duties of a public health program. There are multiple agencies from every level of government that must be involved in efforts to protect the public's health. The responsibility is awesome. To meet the challenges a functional board is not only essential but also mandatory.

The board of health provides help with assessing needs, prioritizing, and dealing with calls from the community on health related issues, assists with policy development, improves working relations between sanitarians and other health department staff and finally ensures compliance with the state statutes.

In the area of **assessment,** the analysis and identification of trends is only part of the picture. Resources are finite, therefore priorities must be established and the community

must agree on a plan for improvement. A functional board of health can provide input and guidance to the department as it assesses the vast needs of the community and determines a strategic plan for addressing them.
Additionally, the effectiveness of the intervention must be measured and entered into the political process or **policy development** in order to assure and modify continuing community support. Local boards of health play a very important role as links with the community as a whole, advocate for the development of programs within the health department and act as a liaison to the state legislature.

Assurance is improved when the board of health is strong. The board brings the environmental health and human health sides of public health together to assure that the public's health is improved in all areas. With increased concerns about emergency preparedness, boards of health must be well-versed in responding to health emergencies. The only way to be prepared is to practice and, since there are not many large scale emergencies, systems must be in place to deal with day-to-day health issues. Boards must be prepared to respond to the daily issues in order to respond to big emergencies.

Most importantly, health departments are essentially established through the board of health statutes. The first step in assessing a board of health requires looking at what is mandated in the Montana Code Annotated. The duties of a board of health are outlined specifically in Sections 50-2-101 through 50-2-116, MCA. A tool that I used can be seen in the document following this article. Under each specified duty I was able to assess if our Board was compliant. Once the assessment was complete I was able to approach the commissioners to reorganize our current board to become a "functional" board. The process was also enhanced through support from the health officer and the county attorney. They both saw the need to have a board that would not only comply with the statutes, but also provide support for the public health cases in which they were involved.

Once the current board of health was assessed, the following steps were taken:

- We joined the National Association of Local Boards of Health (NALBOH).
- We reviewed NALBOH's Board Orientation videotape, Assessment, Policy Development and Assurance: The Role of the Local Board of Health.
- We gathered information from bigger counties with "functional" Boards of Health.
- We received sample board by-laws from other counties.
- We drew up an organizational chart with input from the Sanitarian.
- We reviewed the proposed Board with the Chairman of the Richland County Commissioners.
- We set a date for our first "functional" board of health meeting.

Orientation was critical because most new members had not served on the board in the past and they needed information on their function as board members. A binder was assembled for each member. The new board orientation consisted of a review of the NALBOH Health Board Orientation videotape and a discussion of the orientation worksheets with the new board members. These worksheets included a review of the three core functions of public health.

The Board Member manual consisted of the following sections:

Section 1:

1. Organizational Chart
2. Membership contact information
3. Calendar of meeting dates

Section 2:

1. Functions of the Board of Health
2. Public Health Standards. (I used standards proposed by the State of Washington. These standards were clear and in useable language.)
3. Information on the benefits of Public Health and Montana's System, written by Jane Smilie for the Montana Policy Review, Fall, 2002
4. Public Health Code of Ethics put out by the American Public Health Association.

Section 3:

1. MCA 50-2-101 through 50-2-130
2. Roles and Legal Responsibilities of Local Public Health Officers written by Joan Miles, JD, Health Officer, Lewis and Clark City-County Health Department

Section 4: Proposed By-laws

Section 5: A section to place meeting minutes and other materials related to issues being discussed.

Even with new board orientation, we continue to learn with each meeting. With every issue that is brought before the board, the members become more comfortable making decisions. It has become clear to me that it is essential that a functional board of health be established long before it is needed in an emergency situation. The functions of a board are many and can be complicated; without practice they can not act as they need to when they are called upon. The county commissioners feel that the board of health is a very worthwhile board as it provides the avenue for resolving community health issues that was not readily available in the past. Moreover, the presence of the county attorney at the board meetings provides needed legal advice when making some tough decisions. As counties prepare for public health emergency response, a thorough review of the board of health and how it functions, is essential to lay the foundation necessary for a sustained public health response to both large scale emergencies, and day-to-day threats to our public's health.

A functional Board of Health can provide input and guidance to the department as it assesses the vast needs of the community and determines a strategic plan for addressing them.

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Orientation was critical because most of the new members had not served on the board in the past and they needed some information on their function as board members.

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Meth Labs: An Environmental Hazard

By Joan Miles, MS, JD, County Health Officer and
Laura Behenna, Public Health Information Specialist
Lewis and Clark County

Crank. Crystal. White Crunch. Devil Dust. Sky Rocks. Junk.
These represent just a few of the slang names for methamphetamine. In fact, the Florida Based Koch Crime Institute lists more than 300 nicknames for this extremely dangerous drug. Many more problems are associated with the use and manufacture of methamphetamines, often affecting unsuspecting people. Methamphetamines belong high on the list of emerging public health problems that should seriously concern local health boards and public health professionals in the state.

The individual and societal devastation that results from the use of methamphetamines or "meth" is unfortunately becoming well known. What is less well known is that people who have never used meth and never intend to, may eventually find themselves suffering – even seriously injured – from involuntary exposure to the toxic residue left over from manufacturing the powerful drug. That's because meth labs are proliferating around Montana, both in cities and in rural areas, leaving dangerous waste products in their wake.

The number of meth labs found in the state increased 269 percent between fiscal years 2000 and 2002, from 33 to 122 labs, according to Mark Long, narcotics chief at the Montana Department of Justice. The state's costs for getting those labs cleaned up by a professional hazardous waste disposal team went from $235,000 in 2000 to $1,005,000 in 2002.

The problem, however, is that hazardous materials personnel are not responsible for cleaning up all the invisible residues that result from the chemical manufacturing of meth. That task is left to the owner of the property where the lab was found, or is simply left unaddressed.

Meth is relatively easy to make, using readily available household and farm chemicals, such as household cleaners, lye, acetone and anhydrous ammonia. The meth-cooking process, often combining several of these chemicals, can create poisonous gases, liquids and solids that linger in the residences, motel rooms and vehicles that have served as meth labs. Many of these substances threaten both human health and the natural environment.

According to the Koch Crime Institute, every pound of meth produced leaves six pounds of toxic by-products that the meth cook usually dumps down sinks, drains or toilets. Meth waste has also been found poured onto the ground, in pits or into rivers and streams. Some of the chemicals don't break down naturally and persist in the environment for many years. .

Some meth ingredients and by-products are explosive. One-fifth of the more than 1,600 meth labs raided nationally in 1998 were discovered because of an accidental explosion. Other labs get turned in because neighbors smell strong odors from gases the labs produce.

Toxic gases and liquids produced by the drug manufacturing process commonly soak into fabrics and porous surfaces, such as countertops, carpets, walls, ceilings, drapes, furniture and clothing. Meth waste can also collect in plumbing such as drains, traps and septic tanks. Contaminated septic systems may leach toxins into the groundwater. Chemicals have also been found in ventilation systems, redistributing toxic gases and dust when heating and cooling systems are turned on.

Future occupants of the apartments, mobile homes, motel rooms or rental cars once used as meth labs may be unwittingly exposed to poisonous residues that haven't been properly cleaned up. Usually they don't receive any advance warning that they're going to be entering or using a former meth lab. They may not know anything is wrong until they start suffering from symptoms of exposure to the meth waste residues.
Headaches, burning eyes, nausea and vomiting may be the initial symptoms of exposure. Longer-term exposure to meth residues can cause burns or lead to mental impairment, permanent brain damage, cancer, or breakdown of the mucous membranes in the eyes and lungs. Even small doses of some chemical by-products, such as phosphene gas, can be lethal to people and pets.

As the number of meth labs in Montana increase, the public health concerns resulting from the manufacture of meth are becoming a similarly increasing problem for local health departments in both urban and rural communities. This is an issue that needs the attention of policy makers and local boards of health. The health threats caused by the residues from meth production not only affect the unsuspecting public, but can cause significant problems for realtors, hotel and motel owners, landlords, farmers and other business owners.

During the past several years, Montana has dedicated significant resources to the investigation and breaking down of meth labs and disposal of chemicals found at the sites. However, no resources have been dedicated to dealing with the invisible residues and waste products that remain after a meth lab is discovered. Outside of the initial cleanup, there are no mechanisms in place to insure the site has been made safe for subsequent occupants. Furthermore, no systems are in place to assist property owners who are left with these contaminated sites.

Other states are struggling with these issues as well. Although there are no simple solutions, some of the approaches states have taken to minimize public health threats include producing guidelines for clean-up, establishing standards for monitoring residue levels, or maintaining government programs to oversee and regulate clean-up.

Following passage of Senate Joint Resolution 11 by the 2003 Montana Legislature, the

Interim Committee on Children, Families, Health and Human Services was charged with addressing drug and alcohol problems in the state. While much of the committee's work may focus on drug and alcohol users, this is perhaps the best opportunity to call attention to the public health impact associated with the growing meth problem in our state. To date, efforts by state agencies to address this problem have been largely ineffective.

Boards of health should speak up on these issues and urge legislative action to address this growing public health problem. Some sort of statewide program needs to be authorized and funded in order to protect those victimized by this insidious problem in our communities. The public health consequences and risks that remain after a lab is dismantled are too significant to overlook any longer.

For information on the Interim Committee studying drug and alcohol issues, contact Susan Fox at Legislative Services, 444-3064.

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Many people may be unaware that they are living near a meth lab. Here are some things to look for:

- ***Unusual, strong odors (like cat urine, ether, ammonia, acetone or other chemicals);***
- ***Residences with windows blacked out;***
- ***Renters who pay their landlords in cash, (most drug dealers trade exclusively in cash);***
- ***Lots of traffic—people coming and going at unusual times;***
- ***There may be little traffic during the day, but at night the activity increases dramatically;***
- ***Excessive trash, including large amounts of items such as anti-freeze containers, lantern fuel cans, red, chemically stained coffee filters, drain cleaner and duct tape;***
- ***Unusual amounts of clear glass containers being brought into the home.***

Source: Koch Crime Institute

Following is the review of the statutes the Richland County Health Department provides to new members of the board of health for their orientation.

West Nile Virus! Mad Cow Disease! Bioterrorism! Methamphetamine Labs! Chronic Wasting Disease! Smallpox! Anthrax! Obesity Epidemic! Environmental Degradation! Unaffordable Health Care! How many new challenges can Montana's local public health departments and boards of health meet effectively at one time?

The critical public policy issue facing all of Montana is whether or not the state's local public health infrastructure is able to meet these continually expanding and ever changing public health issues. Have we the capacity, the resources and the political will to assure that the citizens of our state will be protected from risks that appear to change and grow with every passing news report? Are we ready for the challenges of the 21st Century?

Montana's public health system is governed, under state law, by local boards of health. These boards consist of elected officials and citizen volunteers who often provide their time, talent and energy, without compensation, to assure that their local health departments are providing the services essential to public health.

These are the ten essential public health services as defined by the leading U.S. public health organizations:

1. Monitor health status to identify community health problems;
2. Diagnose and investigate health problems and health hazards in the community;
3. Inform, educate, and empower people about health issues;
4. Mobilize community partnerships to identify and solve health problems;
5. Develop policies and plans that support individual and community health efforts;
6. Enforce laws and regulations that protect health and ensure safety;
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable;

8. Assure a competent public health and personal health care workforce;
9. Evaluate effectiveness, accessibility and quality of personal and population-based health services;
10. Research for new insights and innovative solutions to health problems.

These are formidable responsibilities for Montana's local boards of health. Have they risen to the challenge?

Montana's local public health departments vary significantly from one jurisdiction to another. They range from a fully staffed multi-jurisdictional health service district, funded in part, by a voter approved levy in Yellowstone County, to a tiny health department where the part-time health officer receives no compensation. Some local health departments provide thoughtful and systematic orientation and training for their new board members, and others are just beginning to learn what their responsibilities are.

It was recently reported that 15,000 people in France died this summer from an extreme and unprecedented heat wave [Associated Press, *Bozeman Daily Chronicle,* September 10, 2003]. The reported reason this catastrophe occurred was because the majority of French health professionals were on extended holiday and were not available to take care of their people.

While there are difficulties inherent in providing quality public health services in a sparsely populated state, no such crisis will occur here. Montana's public health and health care professionals, and local boards of health are not on holiday. They are working relentlessly to improve our public health infrastructure and they are doing it well.

This issue of Montana Policy Review provides an overview of the wide variety of types of local boards of health across the state, examples of some of the challenges they face and the many innovative approaches used to protect the public health. We titled this issue, "Montana's Boards of Health in Action" simply because that is what they are. They are in action to assure that their citizens are provided with essential public health services.

The critical public policy issue facing all of Montana is whether or not the state's local public health infrastructure is able to meet these continually expanding and ever changing public health issues.

Montana Policy Review

Resources on Public Health For Local Boards of Health

Publications

An Introduction to Montana's Public Health System - The Fall 2002 Montana Policy Review of the Montana Local Government Center is a primer on Montana's public health system. It includes articles on the core functions and essential services of public health and an introduction to Montana's environmental health, mental health care, and bioterrorism preparedness systems. Copies are available by contacting the Montana Office of Public Health System Improvement at (406) 444-4473 or by clicking on the Montana DPHHS Training Institute website: http://mphti.state.mt.us/publications.htm

Montana County Health Profiles – This publication provides useful health and population data for every Montana county. Copies are available by calling (406) 444-4473 or by clicking on the Montana DPHHS Public Health and Safety website under the Health Planning Section: http://www.dphhs.state.mt.us/hpsd/index.htm

Public Health: A Legislator's Guide – This volume describes the American public health system, how it works, and current public health issues and challenges. This is published by the National Conference of State Legislatures and can be purchased by calling their publications department at (303) 364-7812 or by clicking on this website: http://www.ncsl.org/programs/health/publichealth.htm

Websites

Montana Laws and Statutes – The Health and Safety section of the Montana Code (Title 50) contains valuable information for local boards of health on public health laws. This section includes Montana statutes on local boards of health, administration of public health laws, food and consumer safety, and communicable diseases. The website is http://leg.state.mt.us/css/mtcode_const/default.asp

Centers for Disease Control (CDC) – This website is a wealth of information on "hot topics" in public health including West Nile Virus, SARS, chronic diseases, Hantavirus, environmental health, and bioterrorism-related information. http://www.cdc.gov

National Association of Local Boards of Health (NALBOH) – The goals of NALBOH are to provide a national voice for the concerns of local boards of health and to help board members acquire the knowledge, skills and abilities to effectively protect and promote public health in their communities. http://www.nalboh.org/

National Association of County and City Health Officials (NACCHO) – This national organization provides leadership on emerging public health issues and relays vital information to local public health departments. Serves as a national voice for local public health. http://www.naccho.org

National Public Health Performance Standards for Local Boards of Health: The purpose of these standards is to develop measurable performance standards for public health systems and local boards of health. The local governance assessment tool is designed specifically for local boards of health to promote quality improvement and to support the delivery of public health services in their jurisdiction. A copy of the assessment tool is available at this website: http://www.phppo.cdc.gov/nphpsp

Montana Department of Public Health and Human Services: Information about public health issues and organizations in Montana is available on this website. http://www.dphhs.state.mt.us

Montana Public Health Training Institute: This website provides up-to-date information on on-site and distance learning opportunities in public health for Montana public health professionals. http://mphti.state.mt.us

Audiovisuals

These videotapes are available through the Montana Public Health Training Institute at the MT DPHHS. Please contact them a (406) 444-6820.

A Day in the Life of Public Health – Produced by the Kansas Health Foundation. This 10-minute videotape provides examples of the importance of public health.

Assessment, Policy Development and Assurance: The Role of the Local Board of Health
This videotape highlights the role of the board of health with the core functions of public health.

Across the nation, local Boards of Health are an intricate part of the public health system. As the governing body for local health departments, board members are ultimately responsible for the broad purview of public health such as clean air and water, sanitation, containment of communicable diseases, and disaster preparedness. Many new challenges have been added to that list in recent years to include escalating levels of food and environmental toxins, insect and rodent transmitted diseases, chronic diseases, addictive and violent behaviors and, more recently, threats of bioterrorism.

Here in Montana, a project is underway to determine the information, education, networking and training needs of local health board members across the state so that targeted efforts can address those needs.

Your input would be most appreciated. Please complete the following questionnaire and mail to the address listed below.

1. Name_____ Title _____
(e.g. board member, county health director, Legislator, MACO member)

Location:_____
City County

2. In your opinion, what is the highest priority training need for your local health board members?

_____
_____

_____

3. Do you provide any type of orientation for local board of health members?
_____ Yes _____ No

If so, what resources (print, video, internet) have you used in a board member orientation?

_____
_____

_____
_____

4. If you have developed resources for orienting local board of health members, would you be willing to share these? _____ Yes, I'm including them with this survey _____ No

Would you be willing to participant in a brief telephone interview to discuss your ideas in more detail?

_____ Yes _____ No

Daytime telephone number or email where you can be reached

_____ _____
Phone number Email address

Please tear on perforation and mail your response to: Judy Garrity, P.O. Box 343, Helena, MT 59624
Or e-mail your responses to: judygarrity@cs.com Thank you for your assistance.

Death, Taxes and Emerging Infections

By Todd Damrow, PhD, MPH
Marc Mattix, DVM
Kammy Johnson, DVM, PhD

Boards of Health Survey

Building a Public Health System That is Prepared

Every Day

By Jane Smilie, MPH, Director
Office of Public Health System Improvement

The events of September 11, 2001, and the subsequent anthrax attacks prompted Congress to appropriate funding to the states to ensure the public health system is prepared to respond to public health threats and emergencies including bioterrorism. However, the public health system improvements occurring across Montana as a result of this funding are helping to ensure a system that is more responsive to our citizens in normal times, not just during rare or emergency events.

In February 2002, the State of Montana, through the Department of Public Health and Human Services (DPHHS), received substantial funding from the Centers for Disease Control and Prevention for public health emergency preparedness and response. Over the

past 18 months, funding, training and technical assistance have been made available to every local and tribal and public health agency. Public health agencies across the state have developed substantial expertise, resources and capacities in the areas of:

- controlling communicable disease,
- enhanced public health laboratory services,
- communicating health information, and
- planning for public health emergencies.

Controlling Communicable Disease

The DPHHS has provided funding to local and tribal public health agencies to strengthen communicable disease surveillance and epidemiology activities. Local agencies have created and/or improved their written disease surveillance, investigation and response protocols and procedures. In addition, local agencies have acquired the necessary communications equipment to receive and evaluate urgent disease reports 24 hours per day, 7 days per week. For the first time, the DPHHS is testing Montana hospital emergency room data and information from over-the-counter pharmaceutical sales for use in early detection of disease outbreaks to potentially prevent unnecessary cases and even deaths.

Montana's enhanced communicable disease surveillance and epidemiology system is being fully utilized with this season's West Nile Virus outbreak. System improvements have allowed state and local staff to quickly receive and assess disease reports, and provide information back to health care providers and policymakers. Health care providers can then promptly provide necessary follow up care to patients, while broad-based disease prevention and control messages are provided to the public. The system will continue to be regularly tested and improved, but the DPHHS is optimistic that it will perform well again during the upcoming pertussis (whooping cough) and flu seasons.

Enhanced Public Health Laboratory Services

Until this funding arrived, the Montana Public Health Laboratory (MTPHL) had seen no major renovations since 1955. Over the past 18 months, however, the MTPHL has undergone significant remodeling, allowing laboratory staff to more efficiently and effectively respond to current public health threats, and ensure the lab is capable of detecting potential bioterrorist events. This remodeling involved upgrading a portion of the facility to a bio-safety level 3, installing laboratory security systems and an emergency generator, adding real-time polymerase chain reaction (PCR) testing and upgrading instrumentation.

This enhanced laboratory capacity has allowed the MTPHL to perform additional testing procedures and to improve existing ones. Just last summer, Montana specimens were sent out-of-state to be tested for West Nile Virus. Test results were typically not received for three to six weeks. This year, the MTPHL was able to quickly establish West Nile Virus testing five days per week and report results daily. Montana's new bio-safety level three capabilities are now serving all Montana hospitals with tuberculosis testing that meets national criteria and standards.

Communicating Health Information

The public health emergency preparedness and response funding has allowed the DPHHS to develop an effective communications system among public health agencies and other emergency response partners. The system, called the Health Alert Network, utilizes high-speed Internet access and e-mail to transmit public health messages. In addition, broadcast fax capabilities, and wireless and cellular phones are in place and can be used as a means of redundant communications during an emergency.

State, local and tribal public health agencies have created call-down lists of emergency contacts, databases of media and other communication channels to quickly disseminate emergency public health information. In addition, they have compiled and developed print and electronic resource materials on a variety of public health topics.

The Health Alert Network has allowed public health professionals, health care providers and emergency response personnel to be better-connected everyday and to share public health information during non-emergencies, as well as supporting emergency communication. Public health agencies can use this technology on a day-to-day basis to more-effectively manage public health programs, such as childhood immunizations and maternal and child health programs. The health communication skills that Montana's public health professionals have developed through the preparedness effort can be used routinely to provide information about everyday community health issues from preventing and controlling diabetes to air quality reports during forest fire season.

Public Health Emergency Preparedness Planning and Training

Montana's state, local and tribal health departments have written and tested basic all-hazards public health emergency preparedness and response plans. These plans were completed in collaboration with a variety of partners, including response personnel, law enforcement, hospitals and health care providers. Public health staff have received training in basic emergency response and incident command structures, equipping them to be critical players when responding to local public health emergencies. In addition, recognizing that public health emergencies do not honor jurisdictional boundaries, public health agency leaders have met to discuss sharing of resources and assets during public health emergencies.

Montana Policy Review

The philosopher who came up with the world's short list of life's certainties was

seriously remiss in excluding emerging infectious diseases. Not only are they a life certainty, they predate taxes, and will certainly be around after we're gone. Philosophical indiscretions aside, today's policy makers would be well-served to become aware of the dynamic nature of disease, and its impact on populations and politics.

The emergence of infectious diseases on this planet is not a new-age phenomenon; it has been going on throughout history. Realize that Columbus brought more than just settlers when he sailed the ocean blue. He also brought along their parasites, including the ones that cause measles, smallpox and tuberculosis, which at the time were completely absent from the Western Hemisphere. Similar occurrences happen today and will certainly continue into the future.

The appearance of new microbial threats to human health should not be surprising; it should be expected. We all know that nature exists in very delicate balance, and when that balance is perturbed, Mother Nature will seek to restore it—with very predictable results. Of the many new, emerging, or re-emerging infectious diseases that have surfaced over the years, they have, with few exceptions, been the result of nothing other than man either directly or indirectly, and knowingly or unwittingly tinkering with nature.

Take for example, Legionnaire's disease. It is caused by a bacterium that is ubiquitous in soils and waters the world over. It has been that way forever without a problem. Then in July of 1976 at a Legionnaire's convention in Philadelphia, the organism surfaced as a new human pathogen. The organism was growing in the water of the cooling towers on the roof of the convention center. A new human disease emerged; brought from ancient obscurity by man's modern invention of air conditioning.

Next consider Lyme disease. The cork- screw-shaped bacterium that causes this disease has been transmitted harmlessly by ticks among deer and rodents in our forests for centuries. But then some changes occurred. Human population growth and urban sprawl resulted in townhouses and swing sets displacing wolves, coyotes, foxes, cougars, hawks, owls, eagles, etc., from our fields and forests. The absence of predators controlling deer and rodents among encroaching hordes of humans resulted in unnatural parasite swapping situations—with quite untoward effects on the interfering human invaders. And Lyme disease was born.

Then there's toxic shock syndrome. Over 2,500 cases were reported to the Centers for Disease Control between 1975 and 1984. The cause of toxic shock syndrome was debated for over a decade. We now know that it is caused by certain strains of yet another ancient and ubiquitous organism, the common skin germ, staph. The emergence of toxic shock syndrome is generally attributed to technologic improvements in feminine hygiene products, most notably the development of carboxymethyl cellulose (synthetic cotton) and it's subsequent inclusion in such products because of its superabsorbent characteristics. Since CM-cellulose is a polysaccharide, it can serve as an energy source for some bacteria including staph. It is believed to have promoted the growth of staph by serving as an unnatural source of sugar, resulting in toxic shock syndrome.

And how about West Nile virus? It appeared "mysteriously" in 1999, of all places in the

middle of New York City—not a particularly natural place for an exotic, African virus. Given the unprecedented speed and reaches of travel by today's people and their products, the appearance in America of a virus from the Nile should not be much of a wonder. Such occurrences have caused the Institute of Medicine to opine that in the context of infectious disease, there is no place in the world from which we are remote, and no one from whom we are disconnected. We are all inexorably linked and living anew today in what has become, truly, a global village—and not without consequence.

From the above examples, we must learn that we cannot afford to be complacent regarding infectious diseases. It is a life certainty that they will continue to plague humankind, even in far-flung places like Montana. Both naturally occurring and intentionally introduced biological agents hold increasing potential to threaten health. Important steps must be taken to address the threat; not the least of which is political resolve by local boards of health. The magnitude of the problem requires their commitment. A robust public health system is the best defense again these emerging microbial threats to health.

Today's policy makers would be well-served to become aware of the dynamic nature of disease, and its impact on populations and politics

In the context of infectious disease, there is no place in the world from which we are remote, and no one from whom we are disconnected. We are all inexorably linked and living anew today in what has become, truly, a global village—and not without consequence.
Montana Policy Review

According to the Florida-based Koch Crime Institute, every pound of meth produced leaves six pounds of toxic byproducts that the meth cook usually dumps down sinks, drains or toilets.

During the past several years, Montana has

dedicated significant resources to the investigation and breaking down of meth labs and disposal of chemicals found at the sites. However, no resources have been dedicated to dealing with the invisible residues and waste products that remain after a meth lab is discovered.

Local Public Health Agency Directory

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Blackfeet Tribal Health Department
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End Notes from Responsibilities & Authorities of Local Boards of Health
By Joan Miles

Responsibilities & Authorities of Local Boards of Health

By Joan Miles, MS, JD
Lewis & Clark County Health Officer

Montana's local boards of health are responsible for carrying out the basic public health responsibilities in our communities. If one were to ask what those responsibilities consist of, the traditional public health answer might include the terminology "assessment, policy development, and assurance." What does that mean and how do we do it?

In practice, local boards of health are responsible for assessing health needs in their communities, developing policies and programs to meet these needs, and assuring that the personnel, training, enforcement mechanisms and resources are available to support meeting the community's public health priorities. Several years ago, local, state, and national public health leaders developed a consensus list called the "Ten Essential Public Health Services" needed to carry out these core responsibilities. While this list of essential services answers the "what" part of the question about a local board's responsibilities, it still doesn't answer "how" boards are authorized to carry out these functions.

To understand the specific role of local boards of health in Montana and how public health functions are carried out, we need to examine the powers, authorities and explicit

responsibilities conferred through our state statutes and regulations. Local health departments carry out various public health activities under authority delegated by the legislature to local boards and public health officers. The mandated functions related to public health merely categorize a wide range of responsibilities or services that are carried out in varying degrees in each of Montana's counties and municipal governments. [1]* Additionally, discretionary powers offer local board options to address community health priorities. For these reasons, public health departments and public health services, as well as city or county expenditures dedicated to public health, differ significantly throughout the state.

This article will first review the specific statutory grants of authorities and responsibilities delegated to local boards and local health officers in Montana. The Legislature has clearly required the establishment of health boards in every local jurisdiction and outlined very explicit responsibilities of these boards in order to provide for the well being of Montana's citizens.

The second section will give an overview of some of the guidelines, statutory restrictions and judicial limitations that guide local boards in the implementation of their public health responsibilities. Finally, a brief assessment of current activities in Montana regarding our public health laws will be presented.

**** Endnotes appear on page 39***

Statutory Authorities and Responsibilities:

Montana law requires that each county and first and second class city establish a board of health. (Title 50, Chapter 2, MCA.) By mutual agreement of the applicable governing bodies, city-county or district boards of health representing two or more adjacent counties can be established. [2] The law provides for flexibility in the membership of a local board, but requires a minimum of five persons appointed by either the county or city commissions. In many Montana counties, the board of health consists of the commission members plus two additional appointments; in other instances the board consists entirely of members of the public. By law, the county attorney serves as legal advisor to county or joint city-county boards of health. (50-2-115, MCA.)

Section 50-2-116, MCA sets forth the specific powers and duties of all local boards of health. The board is required to appoint a health officer (either a physician or person with a master's degree in public health or related field) and to employ "necessary qualified staff" to carry out the board's and health officer's public health duties. If the local board fails to appoint a qualified health officer, the Montana Department of Public Health and Human Services (DPHHS) has the authority to make this appointment.

The local board's mandated responsibilities, set forth in sections 50-2-116(1)(f) through (i), MCA, are designed to protect the populace from the spread of communicable diseases. This section of law requires the following:

"Local boards shall … supervise destruction and removal of all sources of filth that cause disease; guard against the introduction of communicable disease; [and] supervise inspections of public establishments for sanitary conditions …" The board is also required to adopt regulations for the control and disposal of sewage from private and public buildings that are not regulated by the State Department of Environmental Quality

(DEQ).

In order to carry out these mandatory duties, the statutes set forth several discretionary powers that can enable a local board to meet its public health obligations in its jurisdiction. Specifically, under sections 50-2-116 (2)(a) through (h), MCA, local boards may do the following:

- adopt and enforce isolation and quarantine measures to prevent the spread of communicable diseases;[3]
- furnish treatment for persons who have communicable diseases;
- prohibit the use of places that are infected with communicable diseases;
- require the disinfection of places infected with communicable diseases;
- abate nuisances affecting public health or bring action necessary to restrain the violation of public health laws or rules.

Local boards are also vested with rule-making authority and can adopt local regulations in several instances, provided they do not conflict with rules adopted by the state. These local rules can address such things as the control of communicable diseases; removal of filth that might cause disease; heating, ventilation, water supply, and waste disposal in public accommodations; maintenance of sewage treatment systems; regulation of the practice of tattooing; or local controls that are part of a clean-up plan at state or federal superfund sites. (50-2-116(2)(j) and (k), MCA.)

The statutes pertaining to local boards also recognize the fact that many jurisdictions in the state cannot adequately fund or perform all these obligations individually. Thus, the law clearly allows local boards to accept and spend funds from sources other than the local tax base or to contract with another local board for all or part of local health services.

As noted earlier, local boards are required to appoint a local health officer. The health officer, whether employed full or part-time by the board, or serving on a contract basis, similarly must comply with specific statutory responsibilities and authorities. The functions carried out by the health officer further enable a local board to meet its legal responsibilities. Specifically, section 50-2-118, MCA, requires the local health officer to do the following:

- Make inspections for sanitary conditions;
- As directed by the local board, issue written orders for the "destruction and removal of filth that might cause disease;
- With written approval of the state health department, order buildings or facilities where people congregate closed during epidemics;
- Report communicable diseases to the state health department;
- Establish and maintain quarantine and isolation measures as enacted by the local board of health;
- As prescribed by rules adopted the state health department, supervise the disinfection of places at the expense of the local board when a period of quarantine ends;
- File a complaint with the appropriate court if public health laws or rules are violated;
- Validate state licenses issued by the state health department.

The above responsibilities are mandated duties that the board-appointed local health officer or the health officer's designee must fulfill. Thus, if the health officer (or designee) does not perform these obligations or is unqualified under the statutory criteria to perform these obligations, a local board must appoint someone who can fulfill these statutory requirements.
While the primary authorities and responsibilities for both local boards and local health officers are contained in Title 50, Chapter 2, there are many other mandatory or discretionary references to local boards and health officers throughout the statutes. This makes it difficult to comprehensively understand all of the local board's responsibilities. When public health matters are being administered, it is critical that the specific governing statute be examined to determine the extent to which local health entities can or must act.

As an example, the Montana Clean Indoor Act specifically requires local boards of health to supervise and enforce the provisions of the act in buildings and establishments in its jurisdiction. (50-40-108, MCA.) Another local board requirement is to "cooperate with and assist" the state livestock department in matters relating to the control of disease in livestock. (81-2-106, MCA.) Also, in order for a mayor to exercise extraterritorial powers for "the purpose of enforcing health and quarantine regulations," both the county commissioners in the affected county and the health board must approve such an exercise of authority. (7-4-4306, MCA.)

A local board may apply for an order from district court to require examination or treatment of a person for tuberculosis provided certain criteria have been met (50-17-105, MCA). Other discretionary authorities afforded local boards include entering into agreements with the Department of Environmental Quality to perform public water supply inspections (75-6-104(12), MCA) and acting as the board of directors for a local water quality district formed pursuant to sections 7-13-4501 through – 4536, MCA.

There are also several instances where local boards are granted quasi-judicial authority to act as an "appeal" board when a decision of the local health officer is challenged or when an exemption from state or local rules is sought. The laws governing licensed facilities such as restaurants, tourist campgrounds and trailer courts, lodging facilities, and swimming pools state explicitly that the local board is the appeal board when the local health officer refuses to validate a license issued by the state. An applicant aggrieved by a decision by the local health officer has 30 days to appeal the decision to the board and the board must then conduct a hearing in accordance with the contested case provisions of the Montana Administrative Procedures Act. [4]

Local boards are also required to adopt standards for considering requests for variances, or exemptions from minimum state standards for sewage disposal on parcels the board is required to review (those that are not regulated by DEQ). These standards must be identical to those adopted by the state Board of Environmental Review (50-2-116(1)(i), MCA.). [5]

With respect to a local board's authority to adopt regulations for sewage treatment and disposal, the specific statutory references noted above refer to parcels "not regulated" by DEQ. However, the issue of a local board's authority to regulate sanitation on subdivisions that are regulated by DEQ was litigated and ruled on by the Montana Supreme Court in *Skinner Enterprises, Inc. v. Lewis and Clark County Board of Health* (286 Mont. 256, 950 P.2d 723, 1997). The Court concluded local boards have discretionary statutory authority to regulate sanitation on all subdivisions regardless of whether they are already regulated by DEQ (286 Mont. 276.). To insure better coordination when subdivisions are reviewed by dual agencies, the 2001 Montana Legislature clarified that state-reviewed subdivisions must obtain local approval before a certificate of survey can be filed in the county where the parcel is located. [6]

Finally, while too numerous to mention here, there are other statutory responsibilities or authorities in the statutes pertaining to local health officers. These should be reviewed by the local board's appointed health officer prior to the health officer undertaking public health activities.

Guidelines and Limitations on the Exercise of Authorities by Local Boards:

The most important limitations on the exercise of authority by a local board of health (or any other government entity) are the constitutional protections afforded all persons in Montana. Historically, public health law struggles to determine the point at which government authority to protect the public must yield to individual rights claims. [7] To pass constitutional review, a careful balancing of individual rights and liberties with the need to protect the public's health must always take place when coercive public health interventions or actions are contemplated. [8]

Both the federal and Montana constitutions delineate fundamental rights and liberties and provide "due process" protections when government action is taken. [9] Thus, even when statutory authority exists for a local board to take action such as implementing quarantine measures or bringing an action to restrain a violation of public health laws or rules, local boards must insure that these measures are carried out in the least restrictive manner possible, provide adequate notice to affected individuals, and provide the right to legal representation and judicial hearing. [10]

Montana's laws governing the control of tuberculosis contain explicit requirements for a hearing and judicial review when a local board applies for an order to require examination or treatment of someone suspected to have been exposed to tuberculosis (50-17-101 through 115, MCA). However, other statutes granting similar powers to local boards are largely silent on these issues. When actions are taken to protect the public, local boards should consult with legal counsel in their counties to insure constitutionally sound procedures are implemented.

Other important guidelines for local boards are contained in Montana's open meeting and public participation laws. Montana is among several states whose constitution and laws unambiguously require that government decision-making processes be conducted openly and with reasonable opportunity for citizens to participate.[11] In normal decision-

making processes, such as acting upon variance requests or adopting rules, there are some basic procedural elements that a local board must meet:

- The meeting must be open to the public (2-3-203, MCA).
- Advance notice of any matters that the board will hear or act upon must be provided to the public. (2-3-103, MCA). These items should be clearly identified on the meeting agenda.
- There must be procedures to allow the public a reasonable opportunity to participate prior to the board making a decision of "significant interest to the public" (2-3-103 and 111, MCA).
- Minutes must be kept of all public meetings and made available for public inspection (2-3-212, MCA). [12]

Exceptions can occur, however, because of the unique nature of a local board's responsibilities involving matters such as communicable disease reports or specific health care information reported to the health officer. Conflicting situations can occur that may require a balancing of an individual's constitutional privacy rights and confidentiality protections with the open meeting requirements. It is not atypical for a local board to have to determine at which point the public's right to know is outweighed by an individual's right to privacy as enumerated in Section 10 of Montana's Constitution. Furthermore, all local public health officials as well as members of the local board are subject to the confidentiality provisions contained in Montana's "Health Care Information Act." (Title 50, Chapter 16, MCA). Moreover, recent federal requirements adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA) hold health officials and health care providers to very high standards of privacy and confidentiality.[13] A prudent course of action is to seek legal counsel if a board needs to discuss or act upon any information that might be considered "confidential health care information."

The most specific statutory limitations and restrictions on a local board's authorities are in the realm of rule making. First, the board is limited to adopting rules where there is express legislative authority. Rules or regulations cannot be enacted that go beyond the scope provided for in the legislative directive. Also, the legislative grants of authority to adopt rules specify that the local rules must "not conflict with rules adopted by the [state]." [14] Thus, the local board's rules cannot be less stringent than comparable state rules and cannot contradict the purpose of the rules adopted by the state. Furthermore, in 1995, the Legislature enacted Sec. 50-2-130, MCA, mandating that local boards must meet strict criteria in order to adopt rules pertaining to the control of sewage if they are "more stringent than the comparable state regulations or guidelines that address the same circumstances." The criteria necessary to justify a more stringent rule include written findings by the local board, based on evidence in the record, that the more stringent requirement will protect public health or the environment; is achievable under current technology and can mitigate harm to the public's health; and is supported by peer-reviewed scientific studies. The board must also consider the costs to the regulated community of meeting the proposed rules. [15]

Is There Need for Reform?

In the aftermath of September 11 and the subsequent anthrax attacks, efforts have been made to review state and federal statutes to insure that public health laws will permit health officials to effectively contain an epidemic caused by an attack of bioterrorism. However, as seen recently with the SARS epidemic, significant threats to the public's health and welfare can result from highly infectious agents that are not the product of intentional actions. Because many public health statutes were enacted in the early 1900's when public health problems focused heavily on sanitation issues, health officials are properly worried that laws may be outdated or inadequate to address current public health threats.

Montana is one of several states undertaking a comprehensive review of public health laws, not only to assess the adequacy of our laws to react to public health emergencies, but to determine if sufficient authority exists to carry out the essential services necessary to protect public health. No one is advocating wholesale revision of Montana's statutes. This is both politically unrealistic and impractical. However, legitimate questions exist regarding some of the outdated language in our statutes and the fact that public health authorities are scattered throughout the codes, making it difficult for public health professionals as well as local boards to comprehensively understand their responsibilities and powers. For instance, do local boards understand what the authority to "abate nuisances affecting public health" or to adopt rules "for the removal of filth that might cause disease" really means? Is it clear to those charged with protecting the public what actions are allowed or the extent to which a board can act under these legislative directives? Do our laws provide adequate powers to address new and emerging health problems in our communities?

The review of Montana's statutes will focus on whether the existing powers as well as limitations on authorities are clear, understandable and sufficient to allow local boards and health officials to appropriately meet public health obligations. [16] If necessary, modifications or revisions will be presented for legislative consideration in future sessions. It is only with a clear and timely statutory framework that local boards will be able to function effectively and fulfill the essential services critical to protecting the public's health.

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Kenneth Weaver. **Governing Montana at the Grassroots** (Local Government Center, Montana State University, Bozeman, 2002.)
Another option provided to municipalities or counties under the local government statutes is to establish a "multijurisdictional service district" to provide health services and health department functions. See 7-11-1102(2)(i), MCA. Yellowstone County currently has the only health jurisdiction organized under this statute. Once established, the health jurisdiction has the same powers and responsibilities set forth in Title 50 and other statutory sections addressing local boards of health.
House Bill 499, passed by the 2003 Legislature clarified that isolation and quarantine powers authorities rest with local boards of health and are administered under the authority of local health officers. The Department of Public Health & Human Services shares this authority and may adopt and enforce quarantine or isolation measures. 50-2-204, MCA.
See Title 2, Chapter 4, Montana Codes Annotated.
See ARM 17.36.922 for the criteria adopted by the Board of Environmental Review pertaining to variances from state regulations.
Section 9, Chapter 280, Session Laws of Montana, 2001.
Lawrence O. Gosten, JD and James G. Hodge, JD. **State Public Health Law Assessment.** (Turning Point National Program Office, University of Washington, April 2002.)
The 1905 Supreme Court Case *Jacobson v. Massachusetts* established that in public health emergencies, there must be a balancing of civil rights and effective public health interventions to protect the public. 197 U.S. 11 (1905).
See Article V, Amendments to the U. S. Constitution, and Article II, Section 17, Declaration of Rights, Montana Constitution (1972).
The Model State Emergency Health Powers Act drafted by CDC, October 2001, includes similar recommendations to insure the protections of civil rights and liberties.
Kenneth Weaver. **Governing Montana at the Grassroots** (Local Government Center, Montana State University, Bozeman, 2002.)
The statutes cited in this section codify the constitutional rights of the citizens of Montana *to participate* in the decisions of their local government (Section 8) and the right to *know, examine and observe* the deliberations of all public bodies (Section 9). The provisions contained in Title 2, Chapter 3 of the codes are referred to as Montana's "sunshine laws" and are among the most stringent in the nation.
Privacy Rule guidelines can be found at the following CDC website: http://www.cdc.gov/privacyrule
Also, the May 2, 2003, Supplement to Volume 52, Morbidity and Mortality Weekly Report (MMWR) contains an extensive discussion of the privacy rule as it pertains to public health.
See, for example, 50-2-116(2)(k), MCA.

Section 4, Chapter 471, Session Laws of Montana, 1995, and legislative history.
The Montana Department of Public Health and Human Services will be conducting this review during the next 2-3 years as part of its public health improvement process. It is anticipated that if revisions are recommended, these will be submitted to the Legislature in 2005 or 2007.

[1] Kenneth Weaver. **Governing Montana at the Grassroots** (Local Government Center, Montana State University, Bozeman, 2002.)
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The following publications are available from the Local Government Center, Wilson Hall, Montana State University, Bozeman, MT 59717

Governing Montana at the Grass Roots: Local Government Structure, Process and Politics
June, 2002, by Kenneth L. Weaver
The author examines the architecture, politics and needed reforms of Montana's local gov ern- ments in the context of the American federal system and Montana state government. Included is a critical analysis of the Montana political system and a detailed description of how local poli- tics shape the policy decisions of county and municipal officials. Other chapters detail local taxes and finances, functions of county and municipal governments and special districts, and self-government powers. Includes the U.S. and Montana

Constitutions. ($25.00 plus $3.00 shipping and handling.)

"Coordination and Communication: A Look at Gallatin County Criminal Justice System Planning"

July, 2002, Eric Bryson

This is a research paper to explore the utilization of the Gallatin County Detention Center and the benefits of local justice planning and coordination. The research suggests alternatives to incarceration which might provide more cost-effective planning for detention center space requirements. (No charge)

Montana's Local Government Review

February 2001, by Kenneth L. Weaver and Judith A. Mathre

The work documents the recommendations and electoral outcomes of every county and municipal voter review study commission for all three cycles of Montana's local government review. Includes an analysis and comparison of local government forms, functions and powers as well as sample charters for each type of local government.($20.00 plus $3.00 shipping and handling.)

Fiscal Impacts of Alternative Development Patterns: Broadwater & Gallatin Counties, MT

October, 1997, by Mark Haggerty

The paper details 2 county fiscal impact studies in SW Montana. In both studies the findings are clear: farmland and open space provide local governments with a surplus of revenue from property taxes and other revenue sources while residential development drains local government coffers. (No charge)

Costs of County and Education Services in Gallatin County, MT

January, 1996, by Mark Haggerty

Paper researches the revenue collected through taxes on different land uses and compares this with the costs of providing services to each of these categories. Helps decision-makers to understand the relationship between cost and revenue streams and alternative land uses. (No charge)

Montana Local Government Profiles

This wall chart, updated annually, presents census, budgetary, taxation, and government structure data for Montana's 128 incorporated municipalities and 56 counties. This quick reference tool provides important overview information at a glance. The latest edition includes FY 2002 fiscal data and 2000 census data. (No charge). The data is also available on our website with a mechanism allowing comparisons between counties and between cities and towns.

Montana Policy Review, Fall 2002

"An Introduction to Montana's Public Health System" This issue is a primer on Montana's public health system. It includes the core functions of a public health system and examples of local public health programs at work in Montana. Also included is a directory of public health and Indian health service personnel. (No charge)

Montana Policy Review, Winter 2002

"Land Use and Growth Policies" Includes articles on land use planning, growth management, making growth pay for itself, federal cropland protection, dealing with fires on

Montana's wild land urban interface. (No charge)

Montana Policy Review, Fall 1998

"Where Do We Go From Here" Deals with issues of tax reform, CI-75, resort taxes, implement- ation of CHIP, and trends in Montana local government. (No charge)

Montana Policy Review, Spring 1998

"Welfare Reform: A Progress Report." Includes articles on Child Care Capacity, CHIP, School Lunch Program, Mean Spirited Politics, and the New West Boom Towns. (No charge)

Montana Policy Review, Fall 1997

"Patterns for Change" Includes articles concerning patterns for change, local government review, fiscal impacts of alternative development patterns, welfare reform, and property tax trends in Montana. (No charge)

Montana Policy Review, Spring 1997

"The Property Tax Puzzle" Property taxes can be a puzzle. This issue deals with property taxes and school finances, equalization, taxes from an agricultural perspective and the property tax freeze and other proposals. (No charge)

Montana Policy Review, Fall 1996

"Welfare Reform: The Montana Situation" The issue covers welfare reform issues facing Montana, tracking success, block grants, FAIM, welfare reform capacity of county government; not-for-profit's viewpoint, and time for action. (No charge)

Montana Policy Review, Spring 1996

"Land Use Decisions and Private Rights" The publication includes an examination of the fiscal impacts of different land uses, ecosystem management and planning, devolution and governing the use of natural resources. (No charge)

Visit our Website at
http://www.montana.edu/wwwlgc

OBJ

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Montana Local Government Profiles

This wall chart, updated annually, presents census, budgetary, taxation, and government structure data for Montana's 128 incorporated municipalities and 56 counties. This quick reference tool provides important overview information at a glance. The latest edition includes FY 2001 fiscal data and 2000 census data. (No charge)

Municipal Financial Trend Monitoring Workbook, 2nd ed. 1998, by John Marks.

A financial management "cookbook" designed to assist municipal clerks and finance officers in communicating financial data to their mayor and council. The workbook includes sample displays of financial trend indicators, easy-to-follow instructions, and blank models suitable to use by local officials. (No charge)

The Public Participation Process Concerning Land Use Planning Issues: Case Studies of Four Counties**,** January 1996, by Debra Beaver.

This paper looks at the public participation process in planning that occurred in four growth counties: Gallatin County, Montana; Park County, Wyoming; Teton County, Wyoming; and Teton County, Idaho. Guidelines developed from their experiences as to what works best to include the public in the planning process. (No charge)

Indian Gaming: Players and Stakes, January 1994, by Dr. Franke Wilmer.

This publication addresses Indian gaming as an economic activity as well as a tradition of many Native American societies. New challenges to Indian sovereignty and jurisdictional disputes involving federal, tribal, state, and local governments are discussed. (No charge)

Montana Policy Review, Winter 2002

"Land Use and Growth Policies" Includes articles on land use planning, growth management, making growth pay for itself, federal cropland protection, dealing with fires in Montana's wildland urban interface. (No charge)

Montana Policy Review, Fall 1998

"Where Do We Go From Here" deals with issues of tax reform, CI-75, resort taxes, implementation of CHIP, and trends in Montana local government. (No charge)

Montana Policy Review, Spring 1998

"Welfare Reform: A Progress Report." Includes articles on Child Care Capacity, CHIP,School Lunch Program, Mean Spirited Politics, and the New West Boom Towns. (No charge)

Montana Policy Review, Fall 1997

Includes articles concerning patterns for change; local government review, fiscal impacts of alternative development patterns, welfare reform, and property tax trends in Montana. (No charge)

Montana Policy Review, Spring 1997

Property taxes can be a puzzle. This issue deals with property taxes and school finances, equalization, taxes from an agricultural perspective and the property tax freeze and other proposals. (No charge)

Montana Policy Review, Fall 1996

The issue covers Welfare Reform: The Montana Situation. Topics include reform issues facing Montana, tracking success, block grants, FAIM, welfare reform capacity of county government, Not-for-Profit's viewpoint, and time for action. (No charge)

Montana Policy Review, Spring 1996

Publication focuses on Land Use: Public Decisions and Private Rights; Fiscal impacts of different land uses; Ecosystem Management and Planning; Devolution; and Governing use of Natural Resources. (No charge)

Public Health Emergency Preparedness and Response Funding

The public health system improvements occurring across Montana as a result of federal public health emergency preparedness funding are helping to ensure a system that is more responsive to our citizens in normal times, not just during rare or emergency events.

This year, the MTPHL was able to quickly establish West Nile Virus testing five days per week and now

reports results daily.
One of the
essential services of public health is to "link people to needed personal health care
services and assure provision of health care when otherwise unavailable."

Tribal Health and Indian Health Service Directors

50-2-116 MCA. The Boards **shall :**

1. Appoint a local health officer.

_____

_____

2. Elect a presiding officer and other necessary officers

_____

_____

_____

3. Employ qualified staff

_____

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_____

4. Adopt bylaws

_____

5. Hold regular meetings, at least quarterly

_____

_____

_____

6. Supervise destruction and removal of all sources of filth that cause disease – *this needs to be defined by the committee. A policy should be developed to:*
   a. Outline who is responsible for follow-up; the point of contact.
   b. Who will be involved in the decision of destruction?
   c. General guidelines on how the health department will be involved and when.

_____

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_____

7. Guard against the introduction of communicable disease – New definition of

"communicable disease" is an illness due to a specific infectious agent or its toxic products that arise through transmission of that agent or its products from an infected person, animal or inanimate reservoir to a susceptible host; either directly or indirectly through an intermediate plant or animal host, vector or the inanimate environment. *What methods are in place to involve the board ?*

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*8.*Supervise inspections of public establishments for sanitary conditions- *Is there a policy in place that shows the Boards supervision of the inspection process?*

_____

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_____

9. Adopt necessary regulations that are not less stringent than state standards subject to the provisions of 50-2-130. These standards relate to the control and disposal of sewage from private and public buildings.

_____

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_____

The Board **<u>may:</u>**

1. Adopt and enforce isolation and quarantine measures to prevent the spread of communicable diseases.
   a. The definition of **"Isolation"** is the physical separation and confinement of an individual or groups of individuals who are infected or reasonably believed to be infected with a contagious or possibly contagious disease from non-isolated individuals, to prevent or limit the transmission of the disease to non-isolated individuals.
   b. The definition of **"Quarantine"** is the physical separation and confinement of an individual or groups of individuals, who are or may have been exposed to a contagious disease, from non-quarantined individuals, to prevent or limit the transmission of the disease to nonquarantined individuals. *Is there a policy in place to ensure a consistent and efficient use of this* power?

_____

_____

_____

2. Furnish treatment for persons who have communicable disease.

_____

_____

_____

3. Prohibit use of places that are infected with communicable disease.
   _____

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_____

4. Require and provide means for disinfecting places that are infected.
   _____

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_____

5. Accept and spend funds
   _____

_____

_____

6. Contract with another local board for all or a part of board duties - *Is there a contract in place for this?*
   _____

_____

_____

7. Reimburse the health officer – *Is there a contract in place?*
   _____

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_____

8. Abate nuisances affecting public health and safety – *See #6 under "the Board shall section"*
   _____

_____

_____

9. Adopt necessary fees to administer regulations for the control and disposal of sewage.

_____

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10. Adopt rules in the following areas that do not conflict with rules adopted by the department:
    a. The removal of filth that might cause disease
    b. Subject to the provisions of 50-2-130 on sanitation in public buildings that affects public health.
    _____

___

c. Rules for heating, ventilation, water supply and waste disposal in public accommodations that might endanger human lives

d. Subject to the provisions of 50-2-130 for the maintenance of sewage treatment systems that do not discharge an effluent directly into state waters and that are not required to have an operating permit as required by rules adopted under 75-5-401 MCA. _____

___

e. For the regulation of the practice of tattooing. This includes registering, inspecting, adopting fees, and assessing sanitation standards.
_____

___

11. Adopt regulations for the establishment of institutional controls that have been selected or approved by: :
    a. The Environmental Protection Agency (EPA) as part of a remedy for a facility under the federal Comprehensive Environmental Cleanup and Response, Compensation, and Liability Act of 1980.
    b. DEQ as part of a remedy for a facility under the Montana Comprehensive Environmental Cleanup and Responsibility Act.

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Worksheet for Assessing Local Boards of Health and Orienting New Members to Statutory Powers and Duties 50-2-116 MCA

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